Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR SAM FINO
14721 COIT ROAD
DALLAS TX 75254

Respondent Name
ARGONAUT INSURANCE CO

Carrier's Austin Representative Box
#17

MFDR Tracking Number
M4-12-2950-01

MFDR Date Received
MAY 22, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the Reconsideration Letter dated October 6, 2011: "The dos 8/8/2011 was denied due to non-authorization. We were not aware that authorization was needed…Now that we are aware we will obtain the necessary authorization prior to seeing him."

Amount in Dispute: $165.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent signed for the Notice of Medical Fee Dispute on May 25, 2012. The respondent did not submit a response for review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 8, 2011	CPT code 99214	$165.00	$164.81

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes.
2. 28 Tex. Admin. Code §134.600 sets out the fee guidelines for the reimbursement of workers' compensation non-emergency health care requiring preauthorization provided on or after May 2, 2006.
3. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. This request for medical fee dispute resolution was received by the Division on May 22, 2012.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated August 19, 2011

- 888 – DISALLOWED: OUR RECORDS INDICATE THAT THIS PROCEDURE WAS NOT AUTHORIZED BY INTRACORP BASED ON MEDICAL NECESSITY.
- A – PRE-AUTHORIZATION NOT OBTAINED

Explanation of benefits dated October 17, 2011
- 224 – DUPLICATE CHARGE.
- 888 – DISALLOWED: OUR RECORDS INDICATE THAT THIS PROCEDURE WAS NOT AUTHORIZED BY INTRACORP BASED ON MEDICAL NECESSITY.
- A – PREAUTHORIZATION NOT OBTAINED

Issues

1. Is the respondent's denial reason code 'A' supported?
2. Is the requestor entitled to reimbursement for CPT code 99214?

Findings

1. 28 Texas Administrative Code, Section §134.600(c)(1)(B) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury…only when the following situations occur…preauthorization of any heath health care listed in subsection (p) of this section was approved prior to providing the health care." The respondent denied the disputed services based on "A – PRE-AUTHORIZATION NOT OBTAINED." In accordance with 28 Texas Administrative Code, Section §134.600(p), preauthorization is not required for the disputed service, CPT code 99214. Therefore, the requestor is entitled to reimbursement in accordance with 28 Texas Administrative Code, Section §134.203(c).
2. In accordance with 28 Texas Administrative Code, Section §134.203(c), reimbursement is recommended as follows:

   CPT code 99214: $54.54 WC CF/33.9764 Medicare CF x $102.67 = $164.81

   The MAR for CPT code 99214 is $164.81. The respondent paid $0.00. The difference between the MAR and amount paid is $164.81; this amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $164.81.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $164.81 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 24, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC

Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.